EXHIBIT 2

June 15, 2015 PPSAT Enrollment Agreement for Pharmacy, Medicaid ID #715572, NPI #149704955

Organization Details

Enrollment Type	Border Cities
Organization	

Provider Name	Provider Office Telephone Number
PLANNED PARENTHOOD SOUTH ATLANTIC	

Provider Federal Tax Identification (TIN) or Employer Identification (EIN)	National Provider Identifier (NPI)	Contact Email Address
[redacted]	1497049555	melissa.stanat@ppsat.org

Do you operate under a trade or company name as a Doing Business As Name (DBA)? ☐ Yes ☑ No

If yes, enter Doing Business As Name (DBA):_____

Years doing business under this name:_____

Have you used a different Doing Business As Name (DBA)? ☐ Yes ☑ No

Former Doing Business As Name (DBA):_____

Provider Type & Specialty

Provider Type:
Pharmacy

Primary Specialty:	Primary SubSpecialty:
Dispensing Physician	No Subspecialty
Secondary Specialty:	**Secondary SubSpecialty:**

Have you received approval from the SC Department of Disabilities and Special Needs(SCDDSN) to provide Early Intensive Behavioral Intervention (EIBI) services? ☐ Yes ☐ No

If Specialty is Psychologist / Behavioral Support:

Do you intend to furnish Disability Determination Special Needs (DDSN) Waiver services? ☐ Yes ☐ No

Primary Practice Address

Street
2712 MIDDLEBURG DR STE 107

City	State/Province	County	Zip Code/Postal Code
COLUMBIA	SC	Richland	29204-2478

Medicare and Other State Medicaid/CHIP Information

Are you currently enrolled in Medicare? ☐ Yes ☑ No

If yes, enter your

Medicare ID number: _____

NPI number:_____

Are you currently enrolled in another state's Medicaid or Children's Health Insurance Program? ☐ Yes ☑ No

If yes, enter your NPI and list the State of Medicaid/CHIP enrollment:

Medicaid ID number: _____

NPI number:_____

Application Fee Notice

The enrollment application fee must be collected prior to executing a provider agreement whether upon an initial enrollment, reactivation, revalidation or an enrollment to add a new practice location. The enrollment application fee is applicable to providers that the Centers for Medicare & Medicaid Services (CMS) has identified as institutional providers. South Carolina Healthy Connections Medicaid recognizes and enrolls the following institutional providers: Ambulatory Surgery Centers, Community Mental Health Centers, Comprehensive Outpatient Rehabilitation Facilities, Durable Medical Equipment, End Stage Renal Disease Facilities, Federally Qualified Health Centers, Home Health Agencies, Hospices, Hospitals, Independent Clinical Laboratories, Pharmacies, Skilled Nursing Facilities and Rural Health Clinics.

Unless you meet the exception criteria below, you may make a payment by electronic check, credit card or by debit from your checking or savings account.

Please Note: Paper checks are not accepted. Once the application fee payment has been made, proceed with completing the enrollment application. To make a payment, click this link: https://ssl.sc.gov/Checkout/DHHS/

The exceptions to this statement are:

- A provider will be exempt from the fee if they have submitted and received approval for a Hardship Waiver request or they can demonstrate they are enrolled or have paid the application fee to Medicare and/or another states Medicaid or CHIP for the same enrollment location jurisdiction. A different enrollment jurisdiction means "a new enrollment with an address different from a currently enrolled location."
- Individual physicians (sole proprietors enrolling with an EIN and Social Security Number (SSN) are considered individuals), non-physician practitioners and non-physician practitioner organizations are exempted from paying the enrollment application fee.

The Hardship Waiver Exception Request form is located in the Forms Section on the SC Healthy Connections Medicaid website. Please Note: The Hardship Waiver Exception Request form and supporting documentation must be completed and submitted to Provider Enrollment after the submission of the enrollment application.
To access the Hardship Waiver Exception Request form, click this link: https://www.scdhhs.gov/provider

Change of Ownership / Merger

Is this application in conjunction with a change of ownership, stock purchase, change in a shareholders/partners percentage of interest in ownership, transfer of title, or a merger? ☐ Yes ☑ No

If yes, fill out the fields below.

Date of ownership change: _____

SC DHHS ID# Assigned to Previous Owner(s): _____

Provider Contact Person (Authorized Individual)

Provider Contact Name		Telephone Number	Telephone Number Extension:
Nancy Martin Long		(919) 832-9061	
Email Address	**Fax Number**	**Other Phone Number**	**Other Phone Number Extension:**
nancy.long@ppsat.org	(919) 833-7526		

Does the contact person have a managing relationship with the applicant? ☑ Yes ☐ No

If yes, fill out the following:

Social Security Number	Date of Birth	Business Relationship to Provider	Familial Relationship to Provider
[redacted]	[redacted]	Managing Employee	None

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From 9:00 AM	From 9:00 AM	From 9:00 AM	From 11:00 AM	From 9:00 AM	From 9:00 AM	From CLOSED
To 5:00 PM	To 5:00 PM	To 1:00 PM	To 7:00 PM	To 5:00 PM	To 1:00 PM	To CLOSED
and						
From	From	From	From	From	From	From CLOSED
To	To	To	To	To	To	To CLOSED

After – Hours Coverage

Type of after-hours or 24/7 responder coverage:

- ☑ Answering Service
- ☐ Answering Machine that gives the number of the provider to call
- ☐ Hospital operator who pages on-call provider
- ☐ Call forward or stay-on-line transferring
- ☐ Nurse Triage Service
- ☐ 24 hour Hospital Switchboard
- ☐ ER Triage
- ☐ Physician on call
- ☐ Other

Other Explanation:_____

Accounting Correspondence/Pay To Address Information

Organization/Business Name
Planned Parenthood South Atlantic

Name (First, Middle, Last)	Suffix	Office Phone Number	Ext
Nancy Martin Long		(919) 832-9061	

Address Line 1	City	Fax Number
100 South Boylan Avenue	Raleigh	(919) 833-7526

Address Line 2	State	Zip	Corresponding Email Address
	NC	27603-1802	nancy.long@ppsat.org

Contact Person for Correspondence

Name (First, Middle, Last)		Suffix	Office Phone Number	Ext
Nancy Martin Long			(919) 832-9061	
Address Line 1	**City**	**State**	**Fax Number**	
100 South Boylan Avenue	Raleigh	NC	(919) 833-7526	
Address Line 2	**Zip**	**Corresponding Email Address**		
	27603-1802			

Does the contact person have a managing relationship with the applicant? ☑ Yes ☐ No

If yes, fill out the following:

Social Security Number	Date of Birth	Business Relationship to Provider	Familial Relationship to Provider
***[redacted]	[redacted]	Managing Employee	None

Interpretation Services

Are Oral Interpretation services available?
☑ Yes ☐ No

Is Braille supported?
☐ Yes ☑ No

Is Sign Language supported?
☐ Yes ☑ No

Languages Supported:

☐ Arabic	☐ Armenian	☐ Chinese
☑ English	☐ French	☐ French Creole
☐ German	☐ Greek	☐ Hindi
☐ Italian	☐ Japanese	☐ Korean
☐ Persian	☐ Polish	☐ Portuguese
☑ Spanish	☐ Tagalog	☐ Thai
☐ Vietnamese	☐ Yiddish	☐ Other:_____

Language Assistance Attestation

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§2000 et. seq.) and regulations pursuant thereto (45 C.F.R Part 80), all providers enrolled in the South Carolina State Plan for Medical Assistance (Medicaid) must take steps to ensure that Medicaid members with limited English skills receive at no cost to the member, the language assistance necessary to afford them meaningful and equal access to the Medicaid benefits and services to which they are entitled. The South Carolina Department of Health and Human Services is responsible for ensuring that providers comply with this requirement. Failure to have and maintain a policy for providing language assistance may result in suspension of Medicaid billing privileges or termination as a Medicaid provider.

☐ I hereby certify that I have in place a Limited English Policy. Details of this Limited English Policy are available upon request and my policy includes language assistance by means of a (select all that apply):

- ☐ Bi-Lingual Staff
- ☐ Language assistance provided by a Professional Language or Interpretation Service
- ☐ Agreement with another provider to provide language assistance

☐ I hereby certify that I do not have in place a Limited English Policy. However, I only provide language assistance to a family member at their request.

☐ I hereby certify that I do not have in place a Limited English Policy.

☐ I have read, understand, and agree with the conditions set forth in the SCDHHS Language Assistance Attestation Authorization Agreement.

Electronically Signed By: **Date signed**:

Special Needs

Please check all that this location is equipped to serve.

☐ Blind/Visually Impaired ☐ Deaf/Hearing Impaired ☐ Physically Handicapped ☐ Sexually Aggressive
☐ Behaviorally Disruptive

Is this location TDD/TTY Equipped? ☐ Yes ☑ No

If yes, what is the TDD/TTY phone number_____

New Patients Accepted

Are you accepting new patients?	**Do you accept siblings of established patients?**
☑ Yes ☐ No	☑ Yes ☐ No

Age and Gender Served

Male:	**Female:**
☐ 0-3 ☐ 3-12 ☑ 12-18 ☑ 18-60 ☑ 60 and Above	☐ 0-3 ☐ 3-12 ☑ 12-18 ☑ 18-60 ☑ 60 and Above

Taxonomy Codes

Taxonomy 1: 3336C0002X	**Taxonomy 2:**	**Taxonomy 3:**	**Taxonomy 4:**	**Taxonomy 5:**
Taxonomy 6:	**Taxonomy 7:**	**Taxonomy 8:**	**Taxonomy 9:**	**Taxonomy 10:**
Taxonomy 11:	**Taxonomy 12:**	**Taxonomy 13:**	**Taxonomy 14:**	**Taxonomy 15:**

Physician Preceptor License Information

Is this section applicable? ☐Yes ☐No

Name (First, Middle, Last)		**Suffix**	**NPI**
Address Line 1	**City**		**License #**
Address Line 2	**State**	**Zip**	**License State**

Licenses

Are you a board certified or board eligible physician? ☐Yes ☐No ☐N/A

Special SC Permit #: not applicable

Provider Qualifications/ Experience:

- ☐ **A)** 2 years of experience working with people with Mental Retardation/Related Disability (Must be checked if provider type is Bachelor's Degree for behavior support.)
- ☐ **B)** 2 years of experience working with people with Traumatic Brain Injury, Spinal Cord Injury, and/or Similar Disability (Must be checked if provider type is Bachelor's Degree for behavior support.)
- ☐ **C)** 1 year of experience working with people with Mental Retardation/Related Disability (Must be checked if provider type is Licensed Professional Counselor.)
- ☐ **D)** 1 year of experience working with people with Traumatic Brain Injury, Spinal Cord Injury, and/or Similar Disability (Must be checked if provider type is Licensed Professional Counselor.)
- ☐ **E)** None Apply

Provider Education/Type: not applicable

NCPDP Number:	**NCPDP Date:**

License Type	License Category	License	State	License #	Effective	Expiration
Professional (Board)	Pharmacy	Pharmacy	SC	15572	07/01/2015	06/30/2016

Do you prescribe medications? ☐ Yes ☒ No

Do you prescribe covered items or services other than medications? ☐ Yes ☐ No

Certifications

Certification Type	CLIA Certification Type	Certifying Entity	Certification #	Effective	Expiration
CLIA	Certification of Compliance	CMS Division of Laboratory Services within the Certification and Survey Group	42D0249573	01/06/2015	01/05/2017

Managing Relationships

As required by 42 CFR Subpart B, the provider must disclose the following for each individual officer, director, managing employee (general manager, business manager, administrator). Failure to provide the required information may result in a denial for participation. In addition to yourself, list any managing relationships below.

Name (First, Middle, Last)	**Suffix**	**SSN** (Last 4)	**Date of Birth**	**Business Relation**	**Other Explanation**	**Familial Relation**
Nancy Martin Long		[redacted]		Managing Employee		None

Sanctions

Has the applicant, owners, or agents ever been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony, or entered into a pre-trial agreement for a felony?

☐Yes ☑No *If Yes, provide details below.*

Has the applicant, owners, or agents ever had disciplinary action taken against any business or professional license held in this or any other state, or has your license to practice ever been restricted, reduced, or revoked in this or any other state or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?

☐Yes ☑No *If Yes, provide details below.*

Has the applicant, owners, or agents ever been denied enrollment, been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state, or been employed by a corporation, business, or professional association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state?

☐Yes ☑No *If Yes, provide details below.*

Has the applicant, owners, or agents ever had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state?

☐Yes ☑No *If Yes, provide details below.*

Sanctions

Has the applicant, owners, or agents ever had civil monetary penalties levied by Medicare, Medicaid, or other State or Federal Agency or Program, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full?

☐Yes ☑No *If Yes, provide details below.*

Does the applicant, owners, or agents owe money to Medicare or Medicaid that has not been paid?

☐Yes ☑No *If Yes, provide details below.*

Has the applicant, owners, or agents ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services?

☐Yes ☑No *If Yes, provide details below.*

Has the applicant, owners, or agents ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?

☐Yes ☑No *If Yes, provide details below.*

Sanctions

Has the applicant, owners, or agents ever been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial?

☐Yes ☑No *If Yes, provide details below.*

Has the applicant, owners, or agents ever been found to have violated federal or state laws, rules, or regulations governing South Carolina's Medicaid program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program and been sanctioned accordingly?

☐Yes ☑No *If Yes, provide details below.*

Has the applicant, owners, or agents ever been convicted of an offense against the law other than a minor traffic violation?

☐Yes ☑No *If Yes, provide details below.*

Trading Partner Agreement

Provider Name	Doing Business As Name (DBA)
PLANNED PARENTHOOD SOUTH ATLANTIC	

Street
2712 MIDDLEBURG DR STE 107

City	State/Province	Zip Code/Postal Code
COLUMBIA	SC	29204-2478

National Provider Identifier (NPI)	Provider Federal Tax Identification Number (TIN)
1497049555	[redacted]

Trading Partner ID

Type of Business
☑ Medicaid Provider ☐ Billing Service ☐ Clearinghouse ☐ Software Vender

Submission Date
06/15/2015

☐ Other:_____

Provider Contact Information

Provider Contact Name	Telephone Number	Telephone Number Extension
Melissa Stanat	(919) 833-7534	6135

Alternate Telephone Number	Alternate Telephone Number Extension	Fax Number

Email Address:
melissa.stanat@ppsat.org

Preference for Aggregation of Remittance Data*
(e.g.,Account Number linkage to Provider Identifier)
☑ Provider Tax Identification Number (TIN) [redacted]
☐ National Provider Identifier (NPI): _____
☐ Social Security Number (SSN): _____

Claims Submission/Retrieval Information

Are you using a clearinghouse, billing agent, or vendor to submit your claims? ☑ Yes ☐ No

If Yes, please indicate the name here: Navicure

South Carolina Medicaid Web-Based Claims Submission Tool

☐ Requesting Access ☐ Link To Existing IDs ☑ No Access Needed

No. of IDs Requested_____ Existing Submitter ID numbers_____

For Software Vendors or Billing Agents only (please complete) Is the SC Web Tool used to submit Claims? ☐ Yes ☑ No

Transaction Requested

Only use this section when you are filing X12 claims directly to SC Medicaid. DO NOT USE if you submit X12 claims through a vendor or clearinghouse.

Transaction	Yes	No
270 - Eligibility IN	☐	☐
271 - Eligibility OUT	☐	☐
276 - Claims Status IN	☐	☐
277 - Claims Status OUT	☐	☐
278 - Authorization	☐	☐

Transaction	Yes	No
820 - Premium Payments	☐	☐
834 - Benefit Enrollment	☐	☐
835 - Electronic Remittance Advice	☐	☐
837I - Institutional Claims	☐	☐
837D - Dental Claims	☐	☐
837P - Professional Claims	☐	☐

TPA Authorization Agreement

☑ I have read, understand, and agree with the conditions set for in the South Carolina Trading Partner Agreement for Electronic Claims and Related transactions.

Electronic Signature of Person Submitting Enrollment *: Nancy Martin Long Submission Date: 06/15/2015

W – 9 Information

Provider Tax Classification

Name:

Business Name: PLANNED PARENTHOOD SOUTH ATLANTIC

Federal Tax Classification:

- ☐ Individual/Sole Proprietor
- ☑ C Corporation
- ☐ S Corporation
- ☐ Partnership
- ☐ Trust/Estate
- ☐ Limited Liability Company
- ☐ Other
  - ☐ S Corp ☐ C Corp ☐ Partnership

Explanation of Other:

Address Information

Address Line 1	**City**	
2712 MIDDLEBURG DR STE 107	COLUMBIA	
Address Line 2	**State**	**Zip**
	SC	29204-2478

List Account Numbers here (optional)

Requestor's name and address

SC Health & Human Services, P.O. Box 8809 Columbia, SC 29202-8809

Part 1: Taxpayer Identification Number (TIN)

SSN	**EIN** [redacted]

Part 2: Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

☑ Electronically signed by

Signature of U.S. Person : Nancy Martin Long

Date: 06/15/2015

Electronic Funds Transfer (EFT) Authorization Agreement

Provider Information

Provider Name	Doing Business As Name (DBA)	
PLANNED PARENTHOOD SOUTH ATLANTIC		
Street		
2712 MIDDLEBURG DR STE 107		
City	**State/Province**	**Zip Code/Postal Code**
COLUMBIA	SC	29204-2478
National Provider Identifier (NPI)	**Provider Federal Tax Identification Number (TIN)**	
1497049555	[redacted]	

Provider Contact Information (*Contact Name may be different than enrolling provider or Contact Person listed in the application.*)

Provider Contact Name		
Nancy Martin Long		
Telephone Number	**Telephone Number Extension**	**Email Address**
(919) 832-7526		nancy.long@ppsat.org

Financial Institution Information

Financial Institution Name		
Wells Fargo, NA		
Street		
150 Fayetteville Street		
City	**State/Province**	**Zip Code/Postal Code**
Raleigh	NC	27601-
Financial Institution Routing Number	**Type of Account at Financial Institution**	
[redacted]	☑ Checking ☐ Savings	
Provider's Account Number with Financial Institution	**Account Number Linkage to Provider Identifier**	
[redacted]	[redacted]	
	☐ National Provider Identifier (NPI): _____	
Reason for Submission: ☑ New Enrollment	☐ Social Security Number (SSN): _____	

I authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

EFT Authorization Agreement

All EFT requests are subject to a fifteen (15) day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

☑ I have read, understand, and agree with the conditions set forth in the SCDHHS Electronic Funds Transfer (EFT) Authorization Agreement and all related transactions.

Electronic Signature of Person Submitting Enrollment:	Submission Date:
Nancy Martin Long	06/15/2015

Special Instructions: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 1, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching reassociation trace number and your ERA can be directed to your Provider Service Center at 1-888-289-0709.

Ownership & Associations

Do you have one or more Shareholders/Partners with 5% or more ownership? ☐Yes ☑No

If yes, please provide information on all shareholders / partners who have 5% or more shares / ownership in the form below.

Ownership Type: Corporation

Existing Shareholder or Partner for Business

Business Legal Name	Employer Identification Number	% Ownership

Ownership & Associations

Do you have one or more Shareholders/Partners with 5% or more ownership? ☐Yes ☑No

If yes, please provide information on all shareholders / partners who have 5% or more shares / ownership in the form below.

Ownership Type: Corporation

Existing Shareholder or Partner for Individual

Name (First, Middle, Last)	**Suffix**	**Date of Birth:**	**SSN** (Last 4)	**Familial Relationship**	**% Ownership**

PARTICIPATION AND PAYMENT AGREEMENT

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE;

- That this agreement shall not be assigned or transferred.

- That upon acceptance of this agreement, the South Carolina Department of Health and Human Services (SCDHHS) will issue a Medicaid provider number.

- That services shall be provided to Medicaid recipients in compliance with Section 504 of the Rehabilitation Act of 1973, as amended; and the Age Discrimination Act of 1975, as amended; the Omnibus Budget Reconciliation Act of 1981, as amended; the Americans with Disabilities Act of 1990 (ADA), as amended; and any regulations promulgated pursuant to any of these Acts.

- In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.) and regulations pursuant thereto, (45 CFR Part 80, 2014, as amended), the provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.

- That provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489 Subpart I and 42 CFR §417.436(d).

- That adequate and correct fiscal and medical records shall be kept to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations, and policies.

- That for Medicaid purposes all fiscal and medical records shall be retained for a minimum period of five (5) years after last payment was made for services rendered, except that hospitals and nursing homes are required to retain such records for six (6) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the appropriate retention period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the appropriate retention period, whichever is later.

- That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment under this agreement to SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the United States Department of Health and Human Services, Government Accountability Office and/or their designee during normal business hours. Failure of the provider to comply with this provision may result in the immediate termination of this agreement. SCDHHS may, upon good cause shown by the provider, and within the discretion of SCDHHS, allow the provider a reasonable amount of time to provide the documents requested. SCDHHS will notify the provider of any termination under this provision by Certified Mail, Return Receipt Requested, or nationally recognized overnight carrier.

- That upon request, information must be furnished regarding any claim for payment to the SCDHHS.

- That requests for reimbursement for services shall reflect any third party payment received and that any payment received subsequent to claims filing shall be reported.

- That Medicaid will reimburse the co-insurance and/or deductible portions (cost sharing) of Medicare claims for recipients with both coverages only if the provider accepts Medicare assignment. Cost sharing is in accordance with the South Carolina State Plan for Medical Assistance.

- That Medicaid reimbursement is always made to the provider of services and that the recipient shall not be billed pending receipt of such payment.

- That Medicaid reimbursement is payment in full and that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient/patient except as may otherwise be allowed under Federal regulations or in accordance with SCDHHS policy. That this statement applies only to those recipients for whom Medicaid claims are filed and that it in no way requires that the provider render services to any Medicaid recipient.

- The provider may terminate this agreement upon providing SCDHHS with thirty (30) days written notice of termination. SCDHHS may terminate this agreement for good cause upon providing the provider with thirty (30) days written notice of termination. Notices of termination shall be sent by Certified Mail, Return Receipt Requested or nationally recognized overnight carrier, and be effective thirty (30) days after the date of receipt. For the purposes of this agreement, 'good cause' shall be a failure of the provider to abide by the terms of this agreement.

- That the provider shall disclose full and complete information as to ownership, business transactions, and criminal activity in accordance with 42 CFR 455 Subpart B (2014, as amended). Furthermore, the provider shall disclose any felony convictions under federal or state law in accordance with 42 CFR 1001 Subparts B and Subpart C (2014, as amended).

- That the provider shall comply with all applicable screening and enrollment requirements in accordance with 42 CFR 455 Subpart E (2014, as amended).

- That, for any dispute arising under this agreement, the provider shall have as his sole and exclusive remedy the right to request a hearing from SCDHHS within thirty (30) calendar days of the SCDHHS action which he believes himself aggrieved. Such proceedings shall be in accordance with SCDHHS appeals procedures and S.C. Code Ann. 1-23-310 et. seq. (1976, as amended). Judicial review of any final agency administrative decision shall be in accordance with S.C. Code Ann. 1-23-380 (1976, as amended).

- That the provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX (Medicaid) services in accordance with 42 CFR Part 431 Subpart F (2014, as amended), SCDHHS regulation §§126-170, et seq., South Carolina Code of State Regulations (2012) Volume 10, as amended, and all applicable State laws and regulations.

- That none of the funds provided under this agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for political office, or otherwise in violation of the "Hatch Act".

- That participation, all services rendered, and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with the South Carolina Plan for Medical Assistance, bulletins, SCDHHS policies, procedures, and Medicaid Provider Manuals.

- That all information provided on the Medicaid enrollment form is incorporated as a part of this agreement.

- That the provider shall be held personally liable for all claims submitted by him or on his behalf as evidenced by his endorsement of his Medicaid reimbursement check or acceptance of an electronic deposit.

- That Medicaid reimbursement (payment of claims) is from state and federal funds and that any falsification (false claims, statement or documents) or concealment of material fact may be prosecuted under applicable state and federal laws.

- That the provider shall comply with all applicable standards of Title VII of the Civil Rights Act of 1964, as amended; the Clean Air Act of 1970, as amended; the Federal Water Pollution Control Act, as amended; Section 6002 of the Solid Waste Disposal Act of 1965 as amended by the Resource Conservation and Recovery Act of 1976; and any regulations promulgated pursuant to any of these Acts.

- That the provider shall comply with all terms and conditions of the Drug Free Workplace Act, S.C. Code Ann. Section 44-107-10 et seq. (1976, as amended) if this agreement is for a stated or estimated value of Fifty Thousand Dollars or more.

- That the provider shall comply with all terms and conditions of the Iran Divestment Act of 2014, S.C. Code Ann. §§11-57-10 et seq. (Supp. 2014, as amended).

- That in accordance with 31 U.S.C. 1352, funds received through this agreement may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all contractors and subcontractors.

- The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Standard Unique Health Identifier for Health Care Providers regulations (45 CFR 162 Subparts A & D), states that all covered entities: health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

- Pursuant to the Standard Unique Health Identifier regulations (45 CFR 162 Subparts A & D), and if the provider is a covered health care provider as defined in 45 CFR §162.402, the provider agrees to disclose its National Provider Identifier (NPI) to SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with SCDHHS.

- That the provider shall comply with all applicable provisions of 2 CFR Part 180 (2014, as amended) as supplemented by 2 CFR Part 376 (2014, as amended), pertaining to debarment and/or suspension. As a condition of participation, the provider should screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program, and/or all federal health care programs. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.

- That if the provider receives annual Medicaid payments of at least Five Million Dollars, the provider must comply with Section 6032 of the Deficit Reduction Act of 2005, Employee Education about False Claims Recovery.

Participation and Payment Attestation

☑ **I certify that I have read the conditions of participation and payment and that I understand and agree to the conditions of the participation and payment agreement and the information I have furnished is true, accurate, complete, and current as of the date of this attestation. I have not herein knowingly or willfully falsified, concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation and that I will report any change affecting my enrollment. I further certify that I will obtain authorization from each Medicaid patient to release to South Carolina Department of Health and Human Services (SCDHHS) medical information necessary for processing Medicaid claims.**

Furthermore, by checking this box, I consent to criminal history background checks including fingerprinting when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider.

Date: 06/15/2015

Participation and Payment Agreement Electronic Signature

☑ **I understand that by checking the electronic signature box of this Participation and Payment Agreement included with the provider enrollment application constitutes a signed contract with South Carolina Department of Health and Human Services.**

Electronically Signed by: Nancy Martin Long

Date: 06/15/2015

SOUTH CAROLINA TRADING PARTNER AGREEMENT FOR ELECTRONIC CLAIMS AND RELATED TRANSACTIONS

I. General

The Trading Partner identified on the *SC Medicaid Trading Partner Agreement Enrollment Form* agrees to the terms and conditions of this Trading Partner Agreement (TPA).

II. Purpose

A. This TPA outlines the requirements for the electronic transfer of protected health information (PHI) between the Trading Partner and the South Carolina Department of Health and Human Services (SCDHHS).

B. The Trading Partner is in the business of submitting said electronic transactions on behalf of itself as a provider or as a billing agent for a provider(s).

C. The exchange of information is for the purpose of allowing Trading Partners to conduct electronic transactions for health care services provided to Medicaid beneficiaries of the SCDHHS. This TPA provides for the exchange of information between these entities necessary for the processing of such transactions. These transactions must be in accordance with the American National Standards Institute (ANSI) accredited standards and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, CFR 45 Parts 160 and 162, Standards for Electronic Transactions, published in the Federal Register August 17, 2000.

D. The Trading Partner is prohibited from transferring PHI received from SCDHHS for any purpose not expressly permitted by and related to paragraphs II A, B, and C above.

III. Provisions of the TPA

A. The Trading Partner agrees to follow the SCDHHS Provider billing guidelines for the submission of Health Care Claim transactions.

B. All transactions must be formatted in accordance with the HIPAA Implementation Guides available at http://www.wpc-edi.com/hipaa. SCDHHS Medicaid Companion Guides, which specify certain situational data elements necessary for SCDHHS, are available at http://www.dhhs.state.sc.us. HIPAA transactions to be exchanged between the Trading Partner and SCDHHS are identified in the SC Medicaid Technical Communications User's Manual.

C. The Trading Partner must complete testing for each of the transactions it will implement and shall not be allowed to exchange data with SCDHHS in production mode until testing is satisfactorily passed as determined by SCDHHS. Successful testing means the ability to successfully pass HIPAA compliance checking and to process PHI transmitted by Trading Partner to SCDHHS. SCDHHS will accept certification from any third-party testing and certification entity that has been identified by the Workgroup for Electronic Data Interchange, Strategic National Implementation Process (WEDI/SNIP) in lieu of a Trading Partner being tested by SCDHHS. Such certification must be at least level 4 as defined by WEDI.

D. The Trading Partner warrants and represents that it has a legally binding contract between itself and all providers for whom it is submitting data or that the Trading Partner is itself a provider authorized to submit claims and receive health care information for beneficiaries who have coverage for services by the SCDHHS.

E. SCDHHS and the Trading Partner will protect the PHI contained in the exchange of information by means of both physical and electronic security measures.

1. Each entity will control access to its physical locations so that only authorized personnel have access to the information.
2. Each entity will utilize passwords in accordance with established procedures so that only authorized personnel have knowledge of those passwords. Upon departure of personnel from employment, the Trading Partner will promptly or immediately notify SCDHHS so that a new password can be established. SCDHHS will establish a similar system for departure of its own employees.
3. Each entity will report to the other any violation of security and/or the release of PHI that is not in accordance with this Agreement.
4. Technical rules for the electronic transfer of PHI between the Parties can be found in the SC Medicaid Technical Communications User's Manual.

IV. Electronic Media Billing

This section applies specifically to Providers and sets forth the necessary procedures for submitting claims electronically. The Provider agrees:

A. To submit claims directly or only through a business agent as defined in 42 CFR 447.10(f) which states:

“Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent's compensation for the service is (1) Related to the cost of processing the billing; (2) Not related on a percentage or other basis to the amount that is billed or collected; and (3) Not dependent upon the collection of the payment." The Provider understands that, in accordance with 42 CFR 447.10(h) "Payment for any service furnished to a recipient by a provider may not be made to or through a factor, either directly or by power of attorney." "Factor” means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the Provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable." (42 CFR 447.10 (b)). Further "payment may be made in accordance with a reassignment from the provider to a government agency or reassignment by a court order." (42 CFR 447.10 (e)).

B. That if the Provider decides to utilize a business agent to submit claims, Provider must authorize the business agent by written contract to submit Medicaid claims in its behalf.

C. To furnish a copy of the aforementioned contract to SCDHHS or its designee upon request.

D. To assure that claims are submitted in the format specified by SCDHHS and to submit test claims for approval by SCDHHS prior to submitting claims for payment.

E. To assure that a transmittal letter is submitted as specified by SCDHHS along with each cartridge/tape/diskette.

F. To correct any and all discrepant claims submitted.

G. To maintain and ensure ready association of electronic claims with source documents, including but not limited to: (1) a signed statement from the patient consenting to the release of information necessary to process claims; (2) justification for rendering services; (3) identification of practitioner rendering services; (4) records corroborating that the services furnished were the same services contained in the claim; and (5) documentation proving that a claim was submitted electronically, by whom it was submitted and when it was submitted.

H. To retain all records for a period of seventy-two (72) months after the close of the federal fiscal year in which the services were rendered.

I. That SCDHHS, the United States Department of Health and Human Services, General Accounting Office, the State Auditor, the Attorney General, or their designees, have the right to audit and confirm information submitted and to access and/or photograph source documents and medical records during regular business hours.

J. That any incorrect payments ascertained as a result of such an audit will be adjusted according to applicable provisions of Title XIX of the Social Security Act as amended, the S.C. State Plan for Medical Assistance, other applicable State and Federal laws and regulations, and SCDHHS Medicaid guidelines.

K. That the submission of an electronic media claim is a claim for Medicaid payment and that "payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State Laws." (42 CFR 455.18(a)(2)).

L. That certain claims may not be submitted electronically and that SCDHHS has the sole authority to determine which claims may or may not be submitted electronically.

M. That under certain circumstances, SCDHHS may require prepayment review of claims and that the Provider will be notified in writing of the SCDHHS's intent to conduct prepayment review during which time electronic claims will not be accepted.

N. That this TPA in no way exempts the Provider from being subject to all other Medicaid regulations in effect at the time the Provider submits a claim.

O. To safeguard and require, in the Provider's written contract with its business agent, that its business agent shall safeguard the use and disclosure of information concerning Medicaid recipients in accordance with all applicable Federal and State laws and regulations. The Provider understands that, in accordance with 42 CFR 431.305(b), "this information must include at least (1) name and address; (2) medical services provided; (3) social and economic conditions or circumstances; (4) agency evaluation of personal information; and (5) medical data, including diagnosis and past history of disease or disability."

P. To be responsible for all services rendered, charges billed, and reimbursement received.

V. Confidentiality

A. The Trading Partner agrees during the term of this TPA, and for a period of six (6) years thereafter, to use the same means it uses to protect confidential proprietary information (including PHI), but in any event not less than reasonable means to prevent the disclosure and to protect the confidentiality both when:

1. Written information received from SCDHHS is marked or identified as confidential.
2. Oral or visual information identified as confidential at the time of disclosure is summarized in writing and provided to the Trading Partner in such written form promptly after such oral or visual disclosure.

B. The foregoing shall not prevent the Trading Partner from disclosing PHI that belongs to the Trading Partner or is:

1. Already known by the recipient entity without an obligation of confidentiality other than under this TPA.
2. Publicly known or becomes publicly known through no unauthorized act of the recipient Party.
3. Rightfully received from a third party.
4. Independently developed by Trading Partner without use of SCDHHS's PHI.
5. Approved by SCDHHS for disclosure.

Trading Partner Agreement Attestation

☑ **I have read, understand, and agree with the conditions set forth in the SCDHHS Trading Partner Agreement for Electronic Claims and Related Transactions.**

Trading Partner Agreement Electronic Signature

☑ **I understand that by checking the electronic signature box of this Trading Partner Agreement, included with this provider enrollment application, constitutes a signed contract with the South Carolina Department of Health and Human Services.**

Electronically Signed by: Nancy Martin Long

Date: 06/15/2015

Provider Enrollment Application Electronic Signature

☑ **I understand that by checking the electronic signature box on the Participation and Payment Agreement, Trading Partner Agreement, Electronic Fund Transfer (EFT) and W-9 request for Taxpayer Identification Number and Certification included with this provider enrollment application constitutes a signed contract with South Carolina Department of Health and Human Services.**

Signed by: Nancy Martin Long

Date: 06/15/2015